



Mental Health Supported Housing

Securing financial stability, supply and quality

By Rethink Mental Illness

In association with HACT and the Centre for Mental Health and supported by the Association of Mental Health Providers (formerly the MHPF)

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Foreword from Mark Winstanley

The value of high quality housing is often underestimated. Having a stable home is a crucial part of sustaining good mental health for all of us and it can also be key to the delivery of high quality, cost-effective community-based services.

Supported housing is a specialist type of housing that helps people with mental illness, and others who may be vulnerable, to live as independently as possible in the community. Its purpose and value is understood in the housing sector, but not necessarily by other public services or the wider public. This is understandable, but regrettable, since its low profile acts as a barrier to increased investment in supported housing.

Rethink Mental Illness provides mental health supported housing schemes across England. Every day we see how people with mental illness benefit from this type of accommodation. We want to see more of this type of housing and our supporters and campaigners are equally unequivocal.

That's why we launched our Place to Call Home campaign after the Government announced plans to radically reform how supported housing is funded. If the proposals are introduced as they currently stand, the viability of mental health supported housing will be threatened, and many of the benefits it brings, both to residents and the public purse, could be lost. Our new research on the types and cost of mental health supporting housing confirms this.

The funding reforms present the most immediate threat to mental health supported housing, but the debate on its future must not begin and end there. It is part of the solution to many of the long-term mental health challenges we face, especially in the NHS. The Five Year Forward View for Mental Health, and parity of esteem, simply cannot be achieved without supported housing. Such housing is uniquely placed to help the NHS meet targets on delayed discharges and out of area placements. It should be at the heart of a national strategy that explicitly recognises this. Any strategy must also address quality. The vast majority of experiences in mental health supporting housing are positive, but to ignore the instances where services could be improved would be remiss.

Our report gives a new level of clarity on the range of provision within mental health supported housing sector. We also present new evidence on costs which shows that the proposed funding reforms do not reflect the breadth of provision and therefore the financial realities of delivering supported housing on the ground.

It's vital that this evidence, and our calls for a long-term vision for the future of the mental health supported housing sector, are recognised by decision makers. That is the only way we can be sure that people severely affected by mental illness will have a place to call home.

Mark Winstanley,

Chief Executive, Rethink Mental Illness

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Executive Summary

Summary

The aims of the Five Year Forward View for Mental Health, and any ambition to achieve parity of esteem between physical and mental health, are undermined if good, affordable and stable housing is not available.

Supported housing is a hugely valuable and cost-effective housing option for people with mental illness. It enables them to live independently in the community and saves the NHS and other public agencies money. Commissioners of health services are beginning to embrace this agenda, but faster action is required if we are to get the quality and quantity of supported housing we need.

However, the future of supported housing is in serious doubt because of Government proposals to radically change how it's funded. Funding is already precarious. New research commissioned by Rethink Mental Illness demonstrates that, under the proposals, those with the highest support needs will no longer have the guarantee of their rent being met by housing benefit. This could spell disaster for people with mental illness and the public services that support them. Urgent action is needed to put supported housing on a firmer financial footing.

Mental health supported housing deserves a higher place on the agenda:

- 1. Parity of esteem is undermined if people do not have access to good housing.**
The role of good housing has been under-played in existing policy on improving mental health services, such as the Five Year Forward View for Mental Health, which aims for more community-based provision. Worse still, attempts to reduce welfare spend threaten to undermine this resource further.
- 2. Supported housing enables people to live independently in the community and is a cost-effective alternative to care and health settings for people with mental illness.** There is huge potential for health and housing to work together for better recovery outcomes. The evidence base for this is already significant. But sustainable funding is key.
- 3. There is a mismatch between current supply and demand for supported housing.** The Government's Supported Accommodation Review acknowledges the disparity but under-estimates the growing demand for this type of provision. This mismatch must be addressed in light of expectations around new models of community-based support and plans to devolve finite supported housing funding to local authorities.
- 4. Supported housing needs to be fully embraced by the NHS.** Silo working at a local level means people with mental illness can miss out on good housing and support that limits hospital stays. It also means the NHS is missing opportunities to deliver big savings. Progress is being made towards integration but we need a step change in how housing and health relate. This relies on certainty in the supported housing funding model.

5. **Proposed funding reforms introduce a huge amount of uncertainty, not least because the Government is yet to undertake an impact assessment of the impact on those who benefit from supporting housing, including those with mental illness.** The Government's plan is an inappropriate starting point, providers are already pulling back, and current shortfalls are expected to become substantially worse over the next decade. A review of funding is welcome but it must be evidence-based.
6. **The Government has yet to undertake an impact assessment on the effect of its proposals on each group. Our research highlights the complexity and range of mental health supported housing and demonstrates that people with the highest support needs are most likely to be affected by the proposals.** This could be disastrous both for individuals with mental illness and the public services who will need to support them.

We recommend:

- **The Government rules out its cap on housing benefit as soon as possible.** The sector needs clarity and assurance that their housing costs will be met in full.
- **The Government should co-produce an alternative funding mechanism.** This should reflect the diversity of the sector and take account of recommendations by a recent Joint Inquiry by the Department for Work and Pensions and Department of Communities and Local Government select committees. This review should encompass the full range of expenditure involved in supported housing provision, including support costs.
- **The Government should commit to a wider joint national strategy that looks at the housing, support and care needs of people with mental illness** and how to support the aims of the Five Year Forward View for Mental Health. Demand already outstrips supply and the gap will continue to grow unless steps are taken to reduce it. This strategy should be jointly led by the Department of Health, Department of Communities and Local Government and the Department for Work and Pensions.
- **The Government needs to develop national guidelines on quality.** The majority of people relying on mental health supported housing gain a huge amount from it. However, the small number that have unsatisfactory experiences could be reduced if standards were introduced.

I. Supported Housing: The Context

Parity of esteem is undermined if people do not have access to good housing. The role of good housing has been under-emphasised in existing policy on improving mental health services, such as the Five Year Forward View for Mental Health, which aims for more community-based provision. Worse still, attempts to reduce welfare spending threaten to undermine this resource further.

I.1 Supported housing can meet lots of NHS challenges

Supported housing is designed to help people who may be more vulnerable to live as independently as possible. This includes older people, people with a learning disability, people who are sleeping rough and people with a mental illness who might otherwise be living in care or health settings.

Therefore, any ambition around parity of esteem between physical and mental health is undermined if good, affordable and stable housing in the community is not available. The NHS still faces huge challenges in reducing repeat hospital admissions, delayed discharges and out of area placements. Supported housing can often serve to prevent a hospital admission, or to shorten a hospital stay because of safety features, and possibly physical adaptations. It can also facilitate and often accommodate dedicated housing support workers and sometimes care staff.

For people with mental illness, 'housing support' often includes help with managing medication and liaison with health services. Housing support staff are often based in supported housing schemes, but 'floating' support staff can visit people not living in these schemes, if funding is available.

I.2 The role of supported housing is under-played in public policy on mental health

The role of housing is relatively low on the mental health agenda considering the impact it can have.

The Five Year Forward View for Mental Health (FYFVMH) and the report by the Commission on Acute Adult Psychiatric Care in England (the Crisp Commission)ⁱ recognise that supported housing has a role to play in delivering positive recovery outcomes and addressing current pressures in the NHS. Both are independent reports and all of the recommendations have been accepted by the Government. The FYFVMH is less explicit about housing but specifically recommends:

- The need to 'build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.'
- That the Government should 'ensure the right levels of protection are in place for people with mental health problems who require specialist supported housing.'
- Increasing 'community based services such as residential rehabilitation and supported housing as a step down for secure care.' The Government sees these 'new models of care' as key to shifting resources away from expensive NHS hospital care, such as stays in secure care, into less restrictive and cheaper housing with support and care in the community.

The Crisp report sets out clearly how secure and settled accommodation could help to reduce the use of NHS services, homelessness and improve wellbeing. The report concludes that supported accommodation should be a 'key component' in the whole-system pathway for people with mental health problems.ⁱⁱ This is in line with an increasing recognition that supported housing should be integrated as part of the acute, secure and rehabilitation care pathwaysⁱⁱⁱ.

1.3 Government interest in supported housing is largely in the context of welfare spending

The Government has taken an interest in supported housing – but through the lens of containing and managing spending on housing benefit and its successor Universal Credit. Seeking to tightly control welfare spending risks an increase in public spending elsewhere and undermines the intent to achieve parity of esteem.

The Government is concerned about the costs of supported housing because tenants are usually eligible for higher rates of housing benefit than other social housing tenants. This is because of higher service charges for these buildings, which in part reflects the cost of managing and maintaining communal and staff areas. Housing benefit must not pay for housing support services, but on-site staff often have a support role as well as a housing management role - this can complicate the distinction. The Government wants to ensure that housing benefit is being used appropriately and also wants a system compatible with Universal Credit.

In 2015, the Government announced that it would be capping the amount of housing benefit payable to those in social housing, including supported housing, at the same rate as the very modest Local Housing Allowance rate. In November 2016, the Government consulted on a locally administered 'top-up' fund to recognise the higher costs of providing supported housing and to address concerns about a shortfall in housing benefit. But it remains true that housing benefit will not automatically cover the full housing costs of supported housing as is the case now.

The Supported Accommodation Review was published at the same time as the Government's consultation paper. It sets out current provision and current housing benefit spending in supported housing. However:

- The Review is not comprehensive – only around half of providers responded
- The Review is limited to housing benefit funding - which covers rents and eligible services charges (in 2015, this amounted to £4.12bn)
- It does not cover care and support costs, which are funded outside of housing benefit. These amounted to £2.05bn^{iv}. The majority of this was from local authorities, but some intensive forms of support are funded through a different mechanism that includes NHS funding^v.

The Government is currently considering whether to implement the housing benefit cap and local top-up fund outlined in its consultation paper. It has received evidence from the sector expressing deep concern about the plans. This includes a critical Joint Select Committee Inquiry report which said that the proposals were unlikely to ensure quality, value for money or protect and boost the supply of supported housing.

We are at a very important crossroads. It is imperative that the Government understands the delicate funding environment that supported housing is already operating within and the risks of upsetting this balance. There is an opportunity too for the Government to take a broader look at mental health supported housing and consider its role in achieving parity of esteem.

2. The value of mental health supported housing

Supported housing is a far cheaper alternative to care and health settings for people with mental illness. There is huge potential for health and housing to work together for better recovery outcomes. The evidence base is already significant. To achieve this potential, a stable financial footing is required.

2.1 The value to individuals

Supported housing enables people with mental illness to live safely and independently, limiting the time they need to spend in restrictive settings.

It is estimated that 1 in 5 people with severe mental illness live in supported housing.

It provides:

- An environment where they can begin or continue their recovery
- A healthy environment that promotes physical and mental wellbeing, as well as the stability and security that comes from a living environment suited to their needs.
- Increased hope, control, and sense of self which helps them plan long-term goals. This offers tenants the opportunity to achieve financial security because of access to welfare benefits and employment
- Help to develop new skills and offers carers assistance and respite in helping those they care for
- Better access to the NHS
- The chance to expand social networks, including the opportunity to seek support from their peers when they are in a crisis.

John

John has schizophrenia and has been in the mental health care system for 32 years, during which time he has moved between hospitals and supported housing in the South of England. Supported housing has enabled him to live independently and manage his medication and he is now ready for a flat of his own. Prior to this, he lived in hospitals and much more restrictive settings.

'My mental and physical health have definitely improved a lot since I first came into contact with mental health services, and particularly as a result of the supported accommodation I've lived in. I've lived in different kinds of residential supported accommodation, including locked rehabilitation units, social housing, and 24 hour supported housing.'

The staff help me to cook for myself and manage my own medication. I've got a weekly food budget which I manage myself, and I'm supported by staff in cooking meals. I'm so grateful for all the support that staff and supported accommodation have given me. I was in hospital and things were going pretty badly for me, but then I was eventually offered a place here and it's like a family. I'll be sorry to leave, but after five and a half years in this service I'm ready to move on.'

Kevin

Kevin lived in supported housing for ten months after separating from his wife in May 2016. He lives with a physical disability and experiences long-term memory loss. He formed friendships there and worked towards getting his own home.

The transition into supported housing was very smooth, although it took some time to get used to my new surroundings. And while I was sad to be separating from my wife, it also felt like a fresh start for me. I don't know how much supported housing helped to improve my mental health because it feels as though it stayed the same. However, I would like to say that the support I received was very positive and helpful throughout.

The support team were there when I needed them. They were excellent. Every week, my case worker visited me and together we reviewed my objectives to ensure I was on the road to recovery. This was a very helpful process and meant that I could work towards moving into my own home once I was ready.

2.2 The wider value of mental health supported housing

There is significant evidence of the wider benefit of supported housing. Its relatively low profile is surprising given its potential to save public services money.

A number of evidence reviews, including by the Mental Health Providers Forum^{vi}, demonstrate the wider benefits.

The Government has stated that the overall benefit of supported housing to the wider public sector stands at £3.5bn per year^{vii}. This is reinforced by evaluations of mental health supported housing projects. For example, Tile House in North London was designed to assist people with severe mental health problems who had spent several years in registered or forensic care homes. The overall annual saving on accommodation and reduced stays in hospital resulting from Tile House alone was £443,964^{viii}.

In addition, there is significant evidence of the value of housing support, such as help with managing medication. Research by Cap Gemini showed that investment of £1.6bn per year in housing support had generated savings of £3.4bn – twice the amount invested^{ix}.

Delayed discharges

Supported housing saves money because its unit prices are significantly lower than those of alternative healthcare providers. A 5% reduction in inpatient bed days potentially frees up £82.5m^x.

The Government's own figures^{xi} show that a 30 day delay from a secure ward costs £16,890, while a 30 day delay from an acute setting costs £13,170.

Freedom of Information requests published by the BBC in August 2017 clearly demonstrate the cost to the NHS of not having the right housing in the community:

- At least 320 patients had to wait 100 days to leave hospital in the past two years across the UK
- At least 91 patients waited more than a year to be discharged, and seven waited more than two years
- A lack of suitable accommodation was often cited as the reason behind the delays.

Findings of this sort are not new. Healthwatch research found that many people are being discharged from mental health hospitals without the right support in the community^{xii}. In 2009, delayed discharge from acute inpatient care owing to a lack of suitable accommodation was estimated to cost the NHS £19m in London alone^{xiii}. More recent analysis by LSE for HACT and the NHF shows that, if all delayed discharges could be eliminated, with appropriate care provided in other services including supported housing, net resources of more than £54m might be freed up^{xiv}.

This supports Rethink Mental Illness' work in secure care. Insights through our Recovery and Outcomes engagement network across low and medium secure care suggests that delayed

discharges from secure care of over eight months or more are common. These delays are often due to a lack of available supported housing and disagreements over funding are common.

Research by HACT and Centre for Mental Health presented in this report demonstrates that the cost of supported housing is often dwarfed by the cost of acute and secure care settings.

3. Current supply of supported housing and demand

There is a mismatch between current supply and demand for supported housing. The Government's Review acknowledges the mismatch but under-estimates the growing demand for this type of provision, particularly in response to the Five Year Forward View and the 'new care models' agenda. Housing providers are already pulling out because of funding uncertainty.

3.1 Current supply

The Government's Supported Accommodation Review is the most current audit we have of supported housing – albeit that less than 50% of providers responded to the Review.

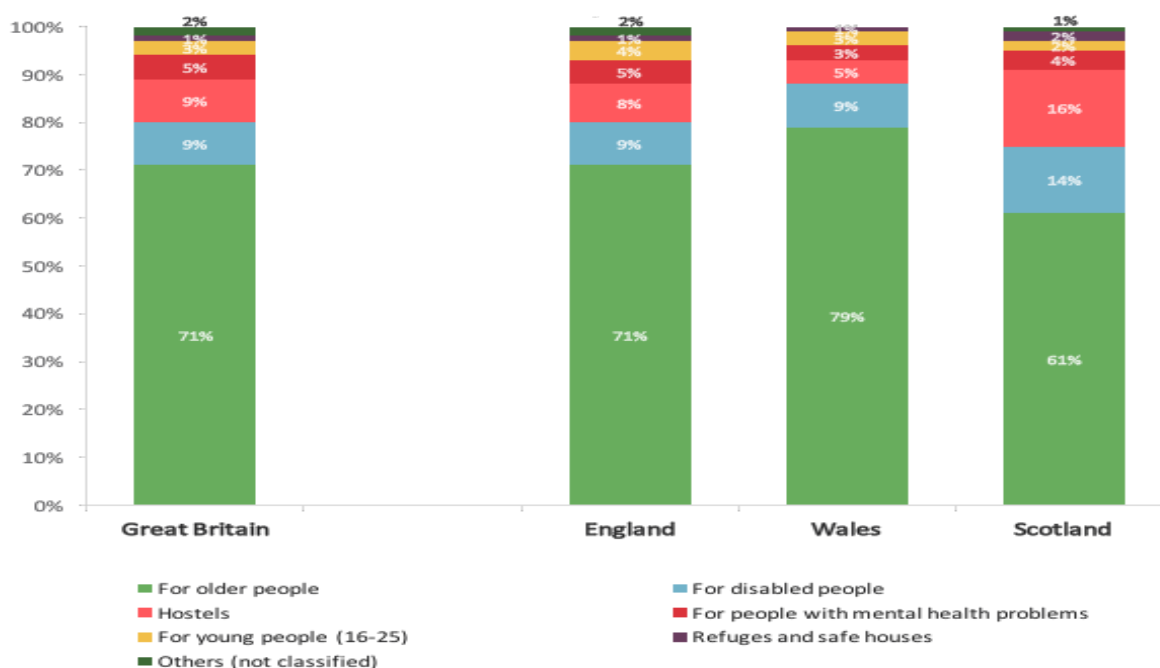
According to the Review, mental health supported housing provision is significant.

- It accounts for 5% of the supported housing sector
- It represents 18% of supported housing provision for working age people (the vast majority of supported housing is for older people)

We also know that at least 4 in 10 people who are homeless have a mental health need (but they are not counted among those living in mental health supported housing).

The review states that around 33,000 people currently live in mental health supported housing in Great Britain (29,500 in England, 2,500 in Scotland, and 1,000 in Wales).

Split of housing stock by client group^{xv}



The range of landlords is broad:

- Housing associations provide the majority of mental health supported housing units, accounting for 22,000 (68.67%).
- Charity and voluntary organisations play a significant role, accounting for 6,000 units (18.9%).
- Other providers, including private landlords, account for 3,000 units (8.9%).

- Local authorities make up the remainder of provision, at around 2,000 units (68%).

Housing associations are also the biggest developers of new mental health supported housing.

It is currently not possible to accurately assess the number of people who receive housing support, including floating support. However, the most recently available figures show that people with mental health problems comprised 9% of all primary clients (239,366 people received a Supporting People-funded service between 1 April 2009 and 31 March 2010). This meant that they made up the third largest group at that time.^{xvi}

3.2 Likely future supply and current pressures

The Government's Supported Accommodation Review is less clear about future demand. Specifically, it does not take into account the Government's own significant plans to deliver 'new care models' and 'step down' accommodation as an alternative to less institutionalised and restrictive settings as set out in the Five Year Forward View for Mental Health. There are particular ambitions around secure care - this specialised form of mental health provision costs £1.2bn to accommodate less than 8,000 people. The NHS stands to realise huge savings if they can reduce admissions and reduce delayed discharges for this restrictive and very expensive form of care.

The National Housing Federation has estimated that there is currently a shortfall of 17,000 supported housing places. This figure is likely to double to over 35,000 places by 2020/21.^{xvii}

Pressures on demand are immense:

- The UK needs to develop between 220,000 and 300,000 new homes annually to address the overall housing shortage.^{xviii} Some tenants are staying in supported housing longer than necessary due to a lack of suitable general needs accommodation. This puts additional pressure on a limited resource^{xix}
- Supply is being constrained as supported housing providers respond to new policies. Supporting People funding changes have already had an impact. From April 2017, the Government imposed a 1% per year reduction in supported housing rents over the next four years^{xx}
- Research^{xxi} suggests that reductions in disability benefits, tightening eligibility criteria and the amount of permitted work claimants are allowed to undertake could compound recent and proposed changes to housing benefit.

Supported housing carries risks for those developing it and is susceptible to public funding uncertainty. This may explain why, since the Government's funding reforms were announced, the number of new supported housing units that housing associations plan to build has fallen by 85%.^{xxii}

Jennifer

Jennifer was in hospital for three years before moving to supported housing. She's been there for four years. She is finding it very difficult to move on because of limited social housing and fears about whether she can afford it.

'Supported housing has helped me in my recovery. There are times when I've been under excruciating stress and staff have really helped me. They help with the practical stuff as well, like doing CVs and helping with benefits, and we have a laugh sometimes, which is all part of recovery.'

But I'm finding it really difficult to move on and I have huge concerns for the future. I work, and the money I make is under the permitted earnings, but there's a catch 22 between wanting to earn more, and wanting to keep getting the benefits which I rely on.

The housing situation is so bleak out there. Social housing is scarce, rents are rocketing, and housing associations are reducing the number of properties they have. I have sleepless nights worrying about housing in the future, I feel so bad about it. I feel I'm made to feel like a scrounger and I worry about that too, but it's such a nationwide issue that many other people must be suffering.'

4. Integrated working – barriers and opportunities

Supported housing needs to be fully embraced by the NHS. Silo working at a local level means people with mental illness can miss out on good housing and support that limits hospital stays. It also means the NHS is missing opportunities to deliver big savings. Progress is being made towards integration but we need a step change in how housing and health relate. This relies on certainty in the supported housing funding model.

4.1 Barriers to access and quality at local level

Silo working at local level can be a barrier to accessing supported housing. Health professionals may not be routinely in touch with housing professionals or be aware of local housing provision.

This may explain in part why people with mental illness are not able to access supported housing. In a survey conducted by Rethink Mental Illness on supported housing¹:

- Only 51% of respondents said that they received the help they needed to find housing following their last in-patient stay
- Only 33% said they were asked about their housing situation on their admission to hospital.

Patients detained under the Mental Health Act are entitled to care and support when they are discharged into the community (known as section 117 funding). Public data on this is not available but anecdotal evidence, including responses to our survey and workshops with secure care residents through the Recovery & Outcomes programme, suggests that this funding is difficult to access.

Access to housing support workers

We also know that difficulties exist in accessing housing support, which includes help with managing a tenancy, budgeting and managing medication. Housing benefit covers around two thirds of the cost of supported housing. The cost of the remaining third (the support and care available on a supported housing scheme) is met by a range of different sources.

Access to 'floating' support can be a problem when people are living in the community. But it can also be a problem for people living in supported housing. This is because support services may be commissioned separately - with a different provider delivering the support. Also, funding for housing support is diminishing following the demise of the Supporting People programme (see 4.2) and this has led to the decommissioning of floating support and accommodation-based support.

Quality of housing support

Even when support is available, the quality of this support is patchy. The vast majority of experiences in mental health supported housing are positive but there are instances where the standards fall short of what tenants and commissioners would expect, and which providers would hope to achieve. This is not helped by different commissioning arrangements and therefore fragmented regulation:

- Oversight of supported housing in England is split between the Homes and Communities Agency (HCA), local authorities and the Care Quality Commission (CQC).^{xxiii}

¹ The online survey was conducted March 2017 and received just over 100 responses. The small sample size is not intended as representative but gives an insight into issues in mental health supported housing.

- There is no mandatory quality framework in place for housing support. The Quality Assessment Framework (QAF) was introduced in 2003 to help providers and commissioners monitor the quality of support funded by the Supporting People programme. After the ring-fence around Supporting People funding was removed and the QAF was revised in 2009, adherence is no longer mandatory^{xxiv}. This may help to explain why some tenants we spoke to were experiencing problems with the quality of support they received in supported housing.

The Government's Supported Accommodation Review acknowledges that the complexity of funding care and support is not conducive to a 'stable, simple and transparent approach to commissioning, funding and providing supported housing that is driven by outcomes for the people who live in it'.^{xxv} This suggests the need for an overarching strategic approach to ensure people with mental illness get the access and quality they need.

Paula

Paula's son, Martin, has lived in supported housing twice since being diagnosed with schizophrenia at the age of 22. His first experience while in supported housing was disastrous – he did not receive any support. Things have improved since he moved to new supported housing accommodation, but the long-term effects of this on Martin's mental health remain to be seen.

'My son, Martin was diagnosed with schizophrenia when he was 22 years old. When Martin came off the medication he had been prescribed, his condition worsened and he had to be hospitalised. After a while, staff at the hospital felt that Martin's condition had improved and encouraged him to move into supported housing.'

Martin moved to a group home with two other residents. We were told that Martin would get a good deal of support from the provider. In reality, he had no weekly meetings or additional support. The only contact he had with the housing provider was when a staff member came to collect rent.

Neither Martin nor I was told when the two other residents moved out of the group home after six months. It was only when I rang the housing provider that I was told they had moved out months earlier. In the end, Martin lived alone with no support for 18 months'.

Katie

Katie has been in inpatient mental health care five times, and has been discharged on each occasion to a government scheme called Staying Put (this involves a placement with a foster family which can last until the foster child is 21.) She feels that she hasn't received appropriate support, and has asked repeatedly that she be moved into mental health supported housing, but has had no success.

'I've been to foster care a number of times after inpatient mental health treatment. I've always fought for more support with my mental health, and I've asked to be put in adult mental health supported housing, but I've not had any luck thus far.'

After my most recent inpatient treatment, the 18+ team just dumped me in short-term housing. It wasn't suitable at all, and there was no real support.. I really want to get housing which supports me more with my mental health and recovery. but I had to go and stay with my dad.

I'm legally entitled to aftercare, but they've told me that I can't get support through it, even when I know

that's not true. I still need supported housing but I don't know if I'll get it or where it'll be. It's just been such a frustrating journey'.

4.2 Barriers to more health-led commissioning of housing, care and support

The NHS has not been a significant player in the commissioning of supported housing since the reduction of the national Supporting People programme.

Supporting People enabled local authorities to buy housing support services within a quality assurance framework through a locally administered government grant. The NHS was a full partner in the creation and delivery of Supporting People. The majority of schemes were provided in the main by housing associations (which still provide the bulk of mental health supported housing) as well as voluntary groups. Over time, schemes developed from shared funding between Supporting People, social and health services and this allowed for a wider range of support services to be provided.^{xxvi}

However, the removal of the Supporting People grant ring-fence in 2010 has had a significant impact on the commissioning of supported housing. The programme fragmented into a system which reflects the broader eligibility for social care funding. As there are variable patterns of local need, local authorities have prioritised supported housing commissioning differently, with some prioritising supported housing for people with learning disabilities and mental health problems, and others prioritising provision for homeless people^{xxvii}. Health commissioners gradually withdrew from the joint commissioning arrangements as adult social care commissioners dominated.

Since the ring-fence was removed, the National Housing Federation has stated that supported housing spending has fallen by 50%.^{xxviii} At the same time, the National Audit Office has reported that Supporting People budgets have been cut by 45% between 2010/11 and 2014/15.^{xxix}

Access to supported housing subsequently became increasingly difficult for people with mental health problems as a result of increased competition for places and the challenging financial environment faced by local authorities.^{xxx}

4.3 Opportunities for more health-led commissioning

The broader landscape of commissioning and funding in the supported housing sector has recently been restructured and there are signs for optimism.

Where people have either support, eligible care needs and/or health needs, or solely support needs, local authorities or NHS Clinical Commissioning Groups will commission mental health supported housing units.

However, as respondents in the Supported Accommodation Review noted, this kind of hands-on approach from an NHS Trust is unusual, and 'the extent of health revenue in funding in supported housing is limited'^{xxxi}. Indeed, when asked to estimate the proportion of funding for supported housing, supported housing providers stated that 5% of their funding was received through NHS Trusts, Clinical Commissioning Groups, and Social Care Partnerships.

NHS Provider Trusts are beginning to take a larger role in commissioning, sometimes working in conjunction with voluntary organisations and specialist housing Registered Providers (usually housing associations) to create this kind of provision. A Trust's goal in commissioning this kind of provision is to tackle longstanding problems in mental healthcare, such as delayed discharges, increasing length of stay, and out-of-area residential care placements^{xxxii}. By working with Registered Providers, NHS

trusts can demonstrate that they can house and support people with mental health problems at lower cost, and with better outcomes, and can form part of supply chains that reform care pathways^{xxxiii}. This approach, however, relies on housing costs to be met by housing benefit.

5. A new and immediate danger – the proposed cap to housing benefit

The Government’s proposed funding reforms are “an inappropriate starting point”. Providers are already pulling out of supported housing development and current shortfalls are expected to become substantially worse over the next decade.

5.1 The Government’s proposed reforms

The Government proposes to limit the amount of housing benefit that can be paid to people living in supported housing.

At present, higher levels of housing benefit can be paid to those in supported housing in recognition of the service charges associated with running supported housing accommodation. These higher levels are agreed with the local housing authority and match the full cost of managing this type of housing.

The Government is suggesting that this is limited, regardless of the service charge costs. The proposed limit is the same level as housing benefit paid in the private sector. The vast majority of tenants in the private sector who claim housing benefit receive the Local Housing Allowance (LHA) rate for their area. The LHA rate is set at the 30th percentile of market rents, according to the size of the property they live in and the area in which the property is located. This is the cheapest form of housing and is not comparable to the costs of providing mental health supported housing. The Government has confirmed that the proposals will apply to new and existing tenants.

The Government has recognised that this may leave some with a shortfall. It has proposed a ring-fenced ‘top-up’ fund to address this shortfall. Local authorities would be responsible for allocating this additional funding in their area².

The total amount that would be devolved to local authorities under the reforms is estimated to be £2.12bn^{xxxiv}. No indication has been given yet of how this funding would be used to fund different types of supported housing, including those schemes that assist people affected by mental health problems.

5.2 The reforms pose significant uncertainty for individuals and housing providers

Supported housing providers have expressed deep concern that the viability and future supply of supported housing schemes will be jeopardised. This is because there will be no guarantee that housing costs will be met in full. These concerns have not been assuaged by a postponement of the cap.

The proposal to implement a cap on housing benefit for those in supported housing will affect the whole sector, yet the implications for those in mental health supported housing are potentially more damaging than for other vulnerable groups. The move from an entitlement-based system to a discretionary one risks the recovery of people living with mental illness and their ability to access supported housing. The new system could trigger huge anxiety as the proposed top-up fund offers no guarantee that individuals will have their housing costs met. And while the Government has stated the overall funding available for supported housing will remain the same, it is not clear how the amount devolved to local authorities will be reviewed in the future to ensure that it meets changes in demand. The removal of the ring-fence around Supporting People funding also sets a concerning precedent for the Government’s new funding proposals. If the ring-fence around the proposed local top-up is removed, the decreases in budget and spending could be repeated. It is also

² Funding arrangements differ in Scotland and Wales. This report focuses on the impact of the reforms to supported housing as they relate to England.

clear that supported housing relies heavily on funding sources outside of housing benefit. These other funding sources, and their interdependencies, are not considered in the Government's reforms and as a result the reforms represent only a partial view of supported housing funding. Existing and future supply is at risk because of the delicate balance of these funding sources.

5.3 Risks to the integration agenda

There are signs for optimism in terms of better relationship between health and housing. However, there is a significant risk that potential health partnerships will be lost if the funding changes go ahead.

NHS, commissioners and new provider-commissioners need to be fully integrated into the new arrangements. Progress made to date to bring supported housing to the awareness of the NHS and include it as part of integrated care pathways could be lost.

The Government's proposed funding reforms reduce the security of the funding base of mental health supported housing and NHS commissioners are not explicitly considered in the proposals. This therefore threatens the progress in integrating mental health supported housing and health. This is despite the increased recognition that mental health supported housing should be a key part of different care pathways.

The estimated additional spend beyond housing benefit for mental health supported housing as a sector in England is £166 million per annum, and constitutes 10% of the additional spend of the supported housing sector.

The total cost of the resources to be devolved to local commissioning under the proposed reforms is estimated to be £2.12bn^{xxxv}. Mental Health accounts for 11% of the commissioned care and support costs but it is not possible to say from the Review what proportion of the £2.12bn that could be transferred locally would be ring-fenced for mental health.

5.4 A Joint Select Committee Inquiry concluded LHA is 'the wrong starting point'

A report by the Inquiry into the Future of Supported Housing (jointly conducted by the Communities & Local Government and Work & Pensions Select Committees) reflected the concern that providers, charities, local authorities and supported housing residents have over the Government's proposals.

The report was clear that 'some providers are reconsidering their investment plans in light of concerns around the long-term reliability of funding' and that 'current shortfalls in provision are expected to become substantially worse over the next decade'. The concerns were echoed in the evidence Rethink Mental Illness gave to the inquiry.

The report concluded that:

- The Government's funding proposals were unlikely to ensure quality, provide value for money, or protect and boost the supply of supported housing
- The LHA rate was an 'inappropriate starting point' for a new funding mechanism as there is no correlation between the LHA rate and the cost of providing supported housing
- The discrepancy between the LHA rate and the cost of provision means that some areas will have 'a far greater reliance' on a local top-up fund than others, which could create 'a disparity in the supply of homes and services in parts of the country'.

The Inquiry recommended that the Government should drop the LHA cap and develop a 'Supported Housing Allowance', with bandings for different types of provision and a cap within each band. This

new mechanism would be calculated using two factors: the cost of provision and a smaller amount of funding that reflects the differences in land values in each area. This funding system would ensure that supported housing residents only require a top-up in 'exceptional circumstances'.

Rethink Mental Illness believes this proposal should be explored and shares the committees' view that the Government should work with the sector to ensure bandings 'adequately reflect the diversity of provision and variation in costs in the sector'.^{xxxvi} Our new research demonstrates that this is not the case as the proposals currently stand.

6. The likely impact of the funding reforms on Mental Health Supported Housing – our research

The Government has yet to undertake an impact assessment on the effect of its proposals on each group. Our research highlights the complexity and range of mental health supported housing and demonstrates that people with the highest support needs are most likely to be affected by the proposals. This could be disastrous both for individuals with mental illness and the public services that will need to support them.

6.1 The Government's Review is insufficient on mental health

No impact assessment has been published on the effect of the Government's proposals. The Government's Supported Accommodation Review lacks the detail to inform any future assessment of the impact on mental health supported housing.

The Review provides only an average cost of mental health supported housing, and gives no insight into:

- the breakdown of the cost base of different forms of mental health supported housing
- what different forms of provision entail
- the care pathways they are part of.

This is important because costs can vary enormously in some types of mental health supported housing. Costs can be particularly high for those with the highest needs who may have moved to supported housing as a 'step down' from institutional settings such as secure care. Some of these costs are support costs – which must not be paid for by housing benefit. However, the buildings may also cost more to run which would make this type of housing very vulnerable to cuts in housing benefit. To address this problem, and provide evidence on the rent and management costs, Rethink Mental Illness commissioned HACT and Centre for Mental Health to:

- identify different types of mental health supported housing (at present, there is no agreement on what the main types are as provision has evolved over the years)
- provide an indication of their housing costs to indicate how far they might diverge from the LHA rate

HACT and the Centre for Mental Health convened a workshop of leading housing providers who manage a range of housing across the major care pathways (Rehabilitation, Acute and Secure Care). These providers identified six broad typologies that captured their range of services. Providers shared their housing costs for each typology, in confidence, with HACT and Centre for Mental Health.

6.2 Mental Health Supported Housing is complex – our six typologies

Our research confirms there is a huge variety in the type of accommodation provided (which may include temporary hostel accommodation), the level of care and support tenants receive and the length of time their tenancies or licence agreements last.

As a result of this complexity there is no single agreed definition of mental health supported housing.

Even though no agreed definition exists, different types of supported housing services have much in common. Residents in mental health supported housing stay in a variety of different types of

accommodation depending on their needs. Some people live in their own flat and receive minimal support, while others live in a group home with others who have similar needs.

Some services are designed to support tenants to make a swift transition to living entirely independently, while others offer more intensive day-to-day support. In more intensive services stays will generally be longer, and on some occasions residents will live in mental health supported housing indefinitely.

The typologies identified in our new research are broad and are not intended to be representative of the entire sector. Yet they provide a new level of insight on mental health supported housing provision.

The research focused on three main adult pathways:

- the Acute Care Pathway
- the Rehabilitation Pathway (sometimes referred to as the Recovery Pathway);
- the Secure Care Pathway.

Full details are set out in the appendix to this report.

Mental Health Supported Housing typologies at a glance

| | |
|---|---|
| <p>Group Home/ Peer Support Housing:</p> <ul style="list-style-type: none"> • Low support • Average length of stay: 2-5 years • Paid with housing benefit (HB) • Not part of a defined NHS pathway | <p>Individual Flats:</p> <ul style="list-style-type: none"> • Short term low support, or very long term high support • Paid with HB • Part of acute pathway |
| <p>Therapeutic Communities:</p> <ul style="list-style-type: none"> • High support • Average length of stay: 2 years • Paid with HB • Part of the Rehabilitation pathway | <p>Temporary 'move-on' flats:</p> <ul style="list-style-type: none"> • Low support • Average length of stay 6-18+ months • Paid with HB • After hostel or therapeutic community • Not part of a defined NHS pathway |
| <p>Mental Health Hostel:</p> <ul style="list-style-type: none"> • Low to high support • Average length of stay: 1-2 years • Paid with HB • Part of the Acute care pathway | <p>Forensic Hostel:</p> <ul style="list-style-type: none"> • High support • Length of stay 18-24 months • Paid with HB • Part of Acute care pathway, Rehabilitation or Secure Care pathway |

Despite, the variety within the sector, the overarching aims and objectives of mental health supported housing are constant. David Rains MBE, Rethink Mental Illness Service Manager at Willow Lodge Supported Housing Service, sets out below what these are and why they are so vital:

‘Everyone deserves to have a place to call home, and for anyone severely affected by mental illness, supported housing can be a lifeline as well as an important stepping stone in managing their mental health problems.

Everyone living in supported housing will come with different requirements for the type and level of support they might need. Each person’s mental health problem, whether that is schizophrenia, depression, or bipolar disorder, will affect their daily lives in different ways.

In order to provide holistic support, there are many areas to consider, from the practicalities of managing bills to help finding a job, or learning how to support your mental health when living independently, including relationships with friends and family, hobbies, or eating well.

Rethink Mental Illness’ supported housing service Willow Lodge, in Folkestone provides housing related and person centred support planning with a focus on promoting independence. Service users stay for up to two years before moving to independent living, and in this time the service supports people in their recovery by building confidence, developing practical skills and the motivation to take the next steps in living independently.

We often find that when people first come to live in supported housing, they can feel like they’ve failed, as their mental illness has meant they’ve been unable to cope with daily life and routines. The basics that some of us take for granted such as going to the shops, cooking and getting enough sleep are often difficult to keep up with. Having a support worker on site, who is able to go shopping for food, help prepare regular meals or just provide reassurance and encouragement can be incredibly beneficial.

People who live in supported housing may have also experienced a number of issues alongside their mental health problems, from losing their job or home, or struggling with strained relationships with family or friends. Supported housing provides a safe and stable environment where people can get back on their feet – for example being supported to start volunteering as a first step back into employment or encouragement to rebuild relationships.

Staff also provide support to transition back to independent living, helping to identify any potential risks and developing the skills needed i.e. budgeting skills or tips for managing and paying bills. One service user had been hospitalised four or five times a year before coming to Willow Lodge. However, because we offered him the security, stability and safety he needed for his recovery, he has not been in hospital at all in the 18 months he has lived here.

Supported housing provides help and guidance tailored to people’s diverse needs as well as a home. As a result during the three and a half years I have been Service Manager at Willow Lodge, all the people who have moved to independent living are still living independently, which is a 100% success rate. Supported Housing isn’t just a safety net - it saves lives, providing people severely affected by mental illness with a safe place to call home when they might need it most’.

6.3 The likely impact of the Government’s funding proposals

The costs of mental health supported housing provision

Our research demonstrates that the Government’s estimates of the costs of mental health supported housing provision are insufficient. The costs of five out of our six typologies are higher, in one case £80 per week higher, than the average costs set out in the Government’s Supported Accommodation Review.

Our concern was that the Review does not reflect the full range of models, and that the average housing cost was a gross under-estimation of the actual costs in mental health supported housing for those with the highest needs. Our research confirms this and shows the effect will be devastating for those in high support housing in particular.

The Government’s Review lists the average core costs of mental health supported housing providers (excluding care and support) as follows:

- Average rent per week: £95
- Average service charge per week: £80
- Average total per week: £175

Our research shows the cost of the most expensive supported housing (for those with high support needs) is £80 higher per week than the average cost quoted in the Review. A large gap between housing costs and the LHA rate would require a huge local top-up, without it the scheme would be unviable.

Figures provided to HACT and Centre for Mental Health confidentially by providers are summarised below. Rent, housing management and service charges are set out for each mental health supported housing typology.

Table 1 – Indicative Mental Health supported housing costs

| Service | A | | B | | C | | D | | E | | F | |
|--|----------------------------|--------------------|------------------------------------|--------------------|-------------------------------------|--------------------|---------------------------|--------------------|-------------------------------|--------------------|--------------------------------|--------------------|
| Service Type | Group Homes | | Mental Health Hostel (low support) | | Mental Health Hostel (high support) | | Move on flats | | Individual flat (low support) | | Individual flat (high support) | |
| | Weekly | % | Weekly | % | Weekly | % | Weekly | % | Weekly | % | Weekly | % |
| Core rent and housing management | £96 (£81 - £111) | 49% (44% - 55%) | £88 (£72 - £104) | 48% (43% - 52%) | £86 (£68 - £104) | 44% (39% - 49%) | £83 (£80 - £85) | 55% (51% - 59%) | £97 (£78 - £116) | 56% (48% - 64%) | £187 (£167 - £207) | 74% (73% - 75%) |
| IHM element and eligible service charge | £91 (£74 - £109) | 46% (39% - 53%) | £86 (£79 - £94) | 47% (39% - 55%) | £82 (£59 - £106) | 42% (33% - 52%) | £68 (£58 - £78) | 45% (41% - 48%) | £77 (£56 - £96) | 43% (35% - 51%) | £49 (£48 - £50) | 19% (17% - 21%) |
| Ineligible service charge | £8 (£4 - £13) | 5% (2% - 8%) | £10 (£4 - £17) | 6% (3% - 8%) | £20 (£17 - £24) | 11% (9% - 12%) | £1 (£0 - £3) | 1% (0% - 2%) | £2 (£0 - £4) | 1% (0% - 2%) | £19 (£15 - £23) | 8% (7% - 9%) |
| Total average costs | £195 | | £184 | | £188 | | £152 | | £176 | | £255 | |
| Weekly shortfall between the | £20 | | £9 | | £13 | | £0 | | £1 | | £80 | |

| | | | | | | | | | | | | | | | | | | | | |
|---------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Review average costs and actual costs | | | | | | | | | | | | | | | | | | | | |
|---------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

The difference is notably higher for tenants with the most acute needs and are therefore most likely to be dependent on a top-up. Among the five typologies where a shortfall was present, the average difference was around £25 a week.

The costs above are not intended to represent the costs of all mental health supported housing provision. The above figures demonstrate the financial gap between the reality of delivering it and the evidence base that informed the Government’s proposal to introduce the LHA cap. More research is needed to gain a fuller picture of the sector’s costs.

Methodology

The values are based on cost data of supported housing schemes from a range of providers. The cost data included the monthly cost per scheme with a breakdown of the percentage of cost coming from core rent and housing management, eligible service charge and intensive housing management, and ineligible service charge.

- The monetary equivalent was calculated per scheme for each cost area. For example, if the monthly cost for a scheme was £500 and the percentage of ineligible service charge was 10%, then the monetary equivalent would be £50. These values were then converted from a monthly to weekly figure.
- The values represented in the table are the mean cost for each area with the range in the brackets representing the 95% confidence interval. The same process was used to calculate the percentage values.

The LHA cap

The figures above need to be understood in the wider context of the LHA cap. The following table sets out what percentage of supported housing tenants, across all types of supported housing, will require a top-up if they are introduced in different parts of the country.

Table 3 – Regional Impact of the LHA Cap^{xxxvii}

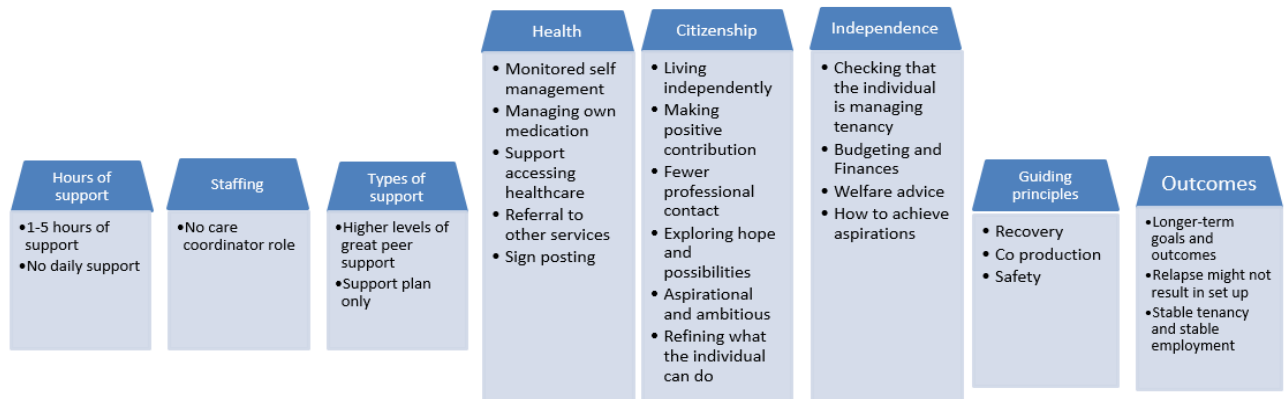
| LHA | East | East Midlands | London | North East | North West | South East | South West | West Midlands | Yorkshire & Humber |
|--|--------|---------------|--------|------------|------------|------------|------------|---------------|--------------------|
| Av weekly amount over cap (£) | 43.62 | 59.28 | 55.67 | 39.78 | 36.38 | 36.72 | 35.26 | 42.08 | 52.62 |
| % of properties affected | 74% | 95% | 15% | 96% | 89% | 49% | 77% | 88% | 89% |
| % of rent roll affected | 24% | 39% | 5% | 30% | 27% | 13% | 20% | 28% | 35% |
| % of total rent and service charge met by capped housing benefit | 76.11% | 60.96% | 94.67% | 69.60% | 73.42% | 86.68% | 79.64% | 72.28% | 65% |
| % for local authority top up | 23.89% | 39.04% | 5.33% | 30.40% | 26.58% | 13.32% | 20.36% | 27.72% | 35% |

The role of housing support

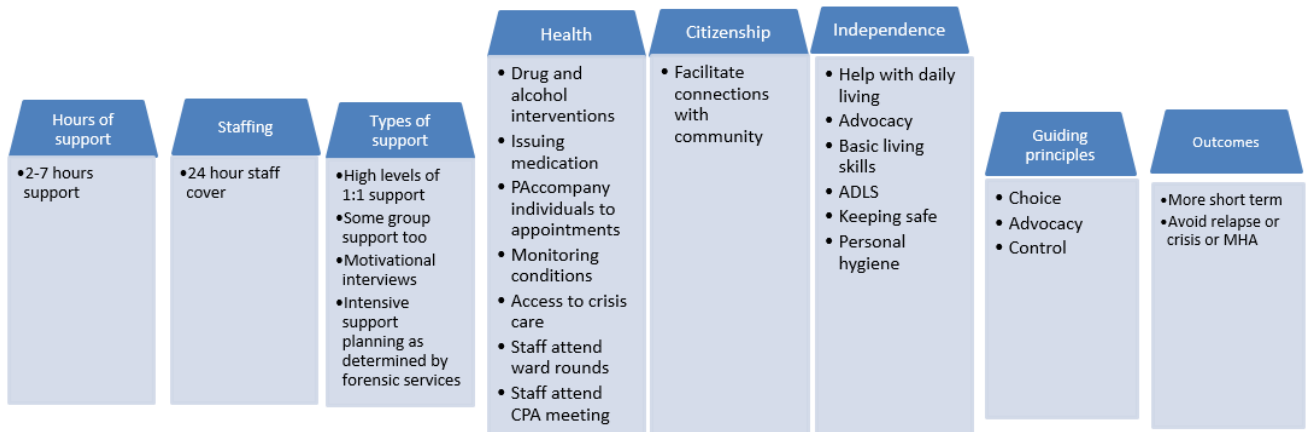
Our research also revealed varying levels of support between schemes. Mental health supported housing tenants may move on a continuum between different levels of support as part of their recovery. The charts below show what different levels of support entail.

This support, and the costs that accompany this, need to be taken into account when considering the financial sustainability of supported housing.

Low levels of support



High levels of support



7. Conclusions

Supported housing can be key to parity of esteem but both supported housing schemes, and the support services within them, need to be put on a firmer footing financially. There is wide agreement about the benefits and an acknowledgement that supply does not meet existing or potential demand.

Quality and continuity of service

This is not to ignore issues around quality and access to housing support, not helped by funding changes that have led to a complex and sometimes fragmented system. Quality and continuity of service for those who need it should be paramount in any reforms. Some of the feedback from our case studies suggests their experience, particularly in relation to housing support, fell short of what people expect.

Renewed interest from health commissioners

There is some way to go before we achieve integrated services with housing recognised as key to parity of esteem. But there are signs for optimism. Health commissioners are showing a renewed interest and beginning to commission supported housing as part of health pathways. They can see how supported housing can address problems around repeat admissions, delayed discharge and out of area placements. There are signs that they are content to fund support and care costs if housing costs are taken care of. The health policy agenda around new models of care should be the catalyst for increased interest and greater supply.

The housing benefit cap threatens progress with health and housing integration

However, the housing benefit cap threatens to destabilise the supported housing sector and to undo progress with the health sector who are not in a position to plug any gaps in housing benefit. The uncertainty alone is driving down supply. The effect is that people with mental illness already face less provision of housing that can help them to live more independently and reduce stays in restrictive settings. This is at a time when we need supported housing more than ever.

Our research shows that the introduction of a housing benefit cap would be disastrous

The Government's proposal does not reflect the actual costs of supported housing. The plan to introduce a 'top up' has prompted widespread concern about how this will be administered in practice and what happens when 'the pot runs out'. The ring-fence around the money handed to local authorities could be removed at any time. The Government has also given no information on how the top-up budget will be continually revised to ensure it meets future need.

Our research supports the findings of the Joint Select Committee. The research seeks to quantify and demonstrate the effects of capping housing benefit in supported housing. For the first time, the complexity and range of provision within the mental health supported housing sector is set out. The research indicates that the majority of mental health supported housing tenants will be reliant on a top-up under the Government's plans to cap housing benefit at the LHA rate and that those with the highest needs are likely to be most affected.

The Government should take the opportunity to take a wider look at housing

The Government is currently taking a very narrow view of supported housing. Welfare and the introduction of Universal Credit is driving the agenda. But the perspective needs to be wider than this. If the Government is intent on parity of esteem and raising the quality of supported housing, it should take a holistic look and put housing front of centre.

Our recommendations

- **The Government needs to rule out its cap on housing benefit as soon as possible.** The sector, and people living in supported housing, needs clarity and assurance that their housing costs will be met in full.
- **The Government should co-produce an alternative funding mechanism.** This should reflect the diversity of the sector and should take account of the Select Committee recommendations. This should encompass the full range of expenditure involved in its provision, including support costs.
- **The Government should commit to a wider joint national strategy that looks at housing, support and care needs of people with mental illness** alongside how to support the aims of the FYFVMH. Demand already outstrips supply and the gap will continue to grow unless steps are taken to reduce it. This should be led by the Department for Health, Department for Communities and Local Government and Department for Work and Pensions.
- **The Government needs to develop national guidelines on quality.** The majority of people relying on mental health supported housing gain a huge amount from it. However, the small number that have unsatisfactory experiences could be reduced if standards were introduced.

Appendix I: The Six Mental Health Supported Housing Typologies

i. Group Homes/Peer Support Housing

This type of supported housing, sometimes known as 'group homes' varies from shared flats to shared houses where there are communal spaces residents can access. The individual is encouraged to live independently and catering is not provided. This type of supported housing does not provide extra security, such as CCTV or double air locked doors and there is no office space for staff.

The average length of stay ranges from two to five years and individuals are provided with low levels of support. Residents do not have a care coordinator or daily support and more emphasis is put on peer support. More general support includes advice and information on welfare matters, support to maintain tenancy and information on budgeting and finances. Individuals are signposted or referred to different services that may be beneficial to them and they receive support in accessing health care.

Individuals tend to make longer term goals or outcomes which may for example be around stable employment and stable tenancy. Residents manage their own medication and a relapse does not necessarily result in step-up of care. Any clinical treatment an individual requires is always provided off-site. Individuals can access any extra support through the night as there is usually a night worker on call.

ii. Therapeutic communities

Therapeutic communities are usually shared houses which have communal areas for individuals to use. They do not provide catering and residents buy their own food, but can share a communal meal too and may cook or eat together. There are no security systems in place (although staff may wear a personal alarm), but staff members are provided with an office space.

The average length of stay is two years and individuals are provided with high levels of support. This is daily support around basic living skills, activities of daily lives (ADLs) and self-management. There are high levels of 1:1 support, there is usually 24-hour staff coverage and there is an emphasis on group or peer support. Treatment is given onsite, and sleeping cover is provided during the night.

Individuals are issued medication and over time are encouraged to manage their own medication. They have access to therapeutic interventions, as well as motivational interviewing and educational sessions around self-awareness and individual triggers which may cause relapse.

Individuals will have access to crisis care and specialist support. Goals and outcomes are more short term around preventing relapse and crisis or being detained under the Mental Health Act. Staff members attend Care Programme Approach (CPA) meetings and accompany individuals to appointments, as well as attending ward rounds.

iii. Hostel mental health

Hostels offer accommodation with differing degrees of support depending on the individual's needs and for this report we have divided them between low support and high support. The average length of stay for both these types of hostel is one to two years.

Low level support hostel residents do not have a care coordinator, or daily support, and an emphasis is put on peer support. The types of support they would receive include advice and information on welfare, support to maintain tenancy and information on budgeting and finances.

Individuals are signposted or referred to different services and receive support in accessing health care. Individuals tend to make longer term goals or outcomes focused on stable employment and

stable tenancy. Residents manage their own medication and relapse does not necessarily result in step-up of care.

Residents using high level support hostels, by contrast, have daily support around basic living skills, ADLs and self-management. Support provided also helps individuals develop their skills to live independently. There are higher levels of 1:1 support, there is usually 24-hour staff coverage but there is still an aspect of group or peer support too. Individuals are issued with medication and over time will be encouraged to manage their own medication.

They may have access to therapeutic interventions, as well as motivational interviewing and educational sessions around self-awareness and individual triggers which may cause relapse. It is also possible that forensic history is taken. Individuals will have access to crisis care and specialist support.

Goals and outcomes are more short term around preventing relapse and crisis or being detained under the Mental Health Act. Staff offer a lot more active support and attend CPA meetings and accompany individuals to appointments.

All hostels have waking night cover and if a person needs clinical treatment they will access it off site. For low support hostels, waking night cover may be more geared towards ensuring security rather than providing support. For high support, it will be for both.

Hostels can refer to a bedsit or individual flats within a shared house or building. There are also differences in the types of security systems provided. Low support hostels have no security system whereas high support hostels have double airlock doors and a concierge.

Both types have communal areas for individuals to use and an office space for staff. A few low support hostels provide catering while in high support hostels this is more common but not universal. Both hostels' pathway is through acute care but high support can also be via rehabilitation. Housing Benefit funds both types of hostel.

iv. Temporary 'move on' flats

Temporary move on flats are clustered flats. They do not have communal areas for residents but they may have office space for staff. There are no extra security features such as CCTV, concierge or double air locked doors but there is on-call night support.

The average length of stay varies from 6-18 months however it can also be a long-term option. Individuals are provided with low levels of support. Residents do not have a care coordinator or daily support and more emphasis is put on peer support. Despite this, the types of support they would receive can include advice information on social security benefits, support to maintain tenancy and information on budgeting and finances.

If a person needs treatment this is usually off-site. Individuals are signposted or referred to different services that may be beneficial to them and they receive support in accessing health care. Individuals tend to make longer term goals and manage their own medication, and relapse does not necessarily result in step-up of care.

Temporary move on flats are funded by Housing Benefit and the pathway is usually from another supported housing scheme such as a hostel or therapeutic community. They are usually a step before general housing.

v. Forensic Hostel

Forensic hostels typically take the form of individual flats in a shared building. They have both office space for staff and communal space for tenants. There are security systems in place such as double airlock doors, CCTV, and a concierge.

The average length of stay is between 18-24 months. There is intensive support and individuals are given daily help with basic living skills, ADLs and self-management. Support provided also helps individuals develop their skills to live independently. There are high levels of 1:1 support, there is usually 24-hour staff coverage but there is still an aspect of group or peer support too. During night, there is waking cover, and if an individual needs treatment it is provided on site.

Individuals are issued medication and over time will be encouraged to manage their own medication. They may have access to therapeutic interventions, as well as motivational interviewing and educational sessions around self-awareness and individual triggers which may cause relapse. Individuals will have access to crisis care and specialist support.

Goals and outcomes are more short term around preventing relapse and crisis or being detained. Staff offer a lot more active support and attend CPA meetings and also accompany individuals to appointments as well as attending ward rounds.

Housing Benefit funds this type of housing and the most common pathways are from secure care. Sometimes referrals come through the acute or rehabilitation pathway where there has been some offending history. Individuals may also take the rehabilitation pathway on exit.

vi. Individual Flats

There are two types of individual flats, ones that provide short term low level support and ones that provide long term high levels of support.

Whilst staying in short-term low-level support individual flats, residents get one hour of support a week. This may include advice and information on welfare and support to maintain tenancy. There is usually no night cover and any clinical treatment the person may need is accessed offsite.

Individuals are signposted or referred to different services that may be beneficial to them and they receive support in accessing health care. Individuals tend to make longer term goals or outcomes and manage their own medication, and relapse does not necessarily result in step-up of care.

Long-term high level support individual flats are very long term and a home for life for residents who have complex difficulties including learning disabilities, mental health problems and forensic acute long term needs. Residents have daily support with basic living skills, ADLs and self-management.

Support provided also helps individuals develop their skills to live independently. There are high levels of 1:1 support, and usually 24-hour staff coverage, but there is still an aspect of group or peer support too. There is also night cover. If an individual needs treatment it is provided offsite.

Individuals are issued medication and may begin to manage this over time. They may have access to therapeutic interventions, as well as motivational interviewing and educational sessions on self-awareness and individual triggers which may cause relapse. It is also possible that forensic history is taken. Individuals will have access to crisis care and specialist support.

Goals and outcomes are more short term around preventing relapse and crisis or being detained. Staff members offer a lot more active support and attend CPA meetings and accompany individuals to appointments as well as attending ward rounds.

Catering is not available for people in short term individual flats but may be available for long term flats. Despite these differences, the physical characteristics of Individual flats are very similar. They

are individual flats but they can sometimes be clustered. Neither type has communal areas, security, or office spaces for staff. Both types of individual flat are funded by Housing Benefit.

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- ⁱ Lord Crisp (2016) *Old Problems, New Solutions: Improving acute psychiatric care for adults in England*
- ⁱⁱ Lord Crisp (2016) *Old Problems, New Solutions: Improving acute psychiatric care for adults in England*, p48
- ⁱⁱⁱ Molyneux, P., van Doorn, A., King, D., & Mothci, D. (2016) *Mental Health and Housing: housing on pathway to recovery*, (HACT, London) – www.housingandhealth.org
- ^{iv} Blood, I., Copeman, I., Finlay, S. (2016) *Supported Accommodation Review: the scale, scope and cost of the supported housing sector* (DWP/DCLG; London)
- ^v Boardman, J. (2016) *More than shelter; supported accommodation and mental health*, Centre for Mental Health, p11
- ^{vi} Boardman, J. (2016) *More than shelter; supported accommodation and mental health*, Centre for Mental Health
- ^{vii} Communities and Local Government and Work and Pensions Committees (2017) *Future of supported housing First Joint Report Session 2016-17*, p7-8
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